RECIPIENT VERIFICATION OF COVERAGE

Michigan Department of Community Health

Medical Services Administration

I understand that Medicaid only covers payment for elective abortions under limited circumstances.

These are:

- ☐ Elective abortion to terminate a pregnancy to save the life of the mother,
- ☐ Elective abortion to terminate a pregnancy that was the result of rape, or
- ☐ Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid coverage for an elective abortion based upon the circumstance(s) that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Family Independence Agency office or to a police agency when appropriate.

Recipient Name (typed or printed)			Signature of Recipient	
Recipient Address				
City	State	ZIP Code	Date Signed	Medicaid Recipient ID No.

WITNESSED BY:

Witness Name (printed)			Witness Signature
Witness Address			
City	State	ZIP Code	Date Signed

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if payment from the Medicaid program is sought.

MSA-1550 (Rev. 5-97) Previous edition may be used